BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

L. WAYNE FINLEY, M.D.

Holder of License No. **14434**
For the Practice of Allopathic Medicine
In the State of Arizona.

Board Case No. MD-03-1096A

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

(Letter of Reprimand & Probation)

The Arizona Medical Board ("Board") considered this matter at its public meeting on February 10, 2005. L. Wayne Finley, M.D., ("Respondent") appeared before the Board without legal counsel for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following findings of fact, conclusions of law and order after due consideration of the facts and law applicable to this matter.,

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 14434 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-03-1096A after receiving a complaint that Respondent, while employed as the Medical Director of a facility in Phoenix, altered radiation logs and failed to properly supervise a Practical Technologist in Radiology ("PTR") by allowing PTR to perform radiological procedures outside his scope of practice.

4. The Board's investigation revealed that the Arizona Radiation Regulatory Agency ("ARRA") inspected the facility where Respondent was employed and determined that, although Respondent had taken x-rays of patients, PTR completed a radiation log indicating PTR took the x-rays. According to the ARRA report, Respondent attempted to

alter the log during the inspection, but was instructed by the ARRA inspector that he was not permitted to do so.

5. The ARRA report listed fifteen incidents of PTR working outside the scope of PTR's license. Initially, Respondent and PTR stated that PTR only assisted Respondent by positioning the patients. However, when advised that positioning a patient was also outside the scope of PTR's practice, both Respondent and PTR recanted their statement. PTR did eventually admit to acting outside the scope of his license by positioning patients.

6. The Board's investigation revealed that a PTR may only perform chest and extremity examinations and that on October 16, 2000 the Medical Radiological Technology Board of Examiners sent a letter to the facility stating the duties of PTRs and clarified that PTRs may not position patients, may not set exposure factors, and may not initiate the exposure. The letter also noted some business managers and physicians are under the false impression that a PTR could perform any portion of the radiographic procedure if he/she was under the direction of a physician. The letter clarified that regardless of supervision, these tasks were outside the approved scope of practice of a PTR.

7. Respondent testified that when he first began his employment in 1999 the facility had a full crew of individuals, including an administrator and a radiological technician who took x-rays head to toe without limitation. Respondent noted that at the time he was a staff physician and there were other front and back office employees. Respondent testified that in 2000 he became aware that a couple of the clinics run by his employer were shut down for unknown reasons. Respondent noted that he knew there were problems with the x-ray department in one of the clinics. Respondent testified that

he did not see the October 2000 letter from the Medical Radiological Technology Board of Examiners until July 2003.

8. Respondent testified that one of his employer's clinics in Peoria, Arizona was closed down for problems related to what a radiological technician could do as opposed to what a practical technician could do. Respondent testified that in 2000 the radiological technician who headed the x-ray department was moved to another facility. Respondent noted that the facility passed inspection in 2000, 2001 and 2002 even though he did not have a radiological technician in the facility. Respondent noted that his employers hired a second PTR. According to Respondent, this PTR worked as a front office person.

9. Respondent testified that he complained to his employer that he could not operate a clinic without a radiological technician because of the applicable laws and he was concerned there would be a violation. Respondent stated he noted his objections right up to the failed July 2003 inspection. Respondent testified that he is now accused of violating the very laws he attempted to avoid violating from the beginning when he continued to urge his employer to bring in a radiological technician because PTRs are not allowed to take x-rays above the elbows. Respondent stated that he was told as long as the PTR did not actually take the film, he was responsible, and the log should have reflected that he took the picture. Respondent noted that PTR took credit for films Respondent had himself taken.

10. Respondent testified that a radiological technician can take any film requested by a physician and has different training and licensure than a PTR. A PTR may also serve as a front office worker, can put on bandages, call insurance companies to get prior authorization, and check on patients. A PTR can also take x-rays of the elbows, wrists, hands, and anything below the elbow, including a chest x-ray, knees,

ankles and feet. Respondent also stated that a PTR can develop films. Respondent testified that he originally thought a PTR could position patients, but learned in 2003 that they could not.

11. Respondent testified that he allowed PTR to be in the room with him when he x-rayed patients and allowed him to position patients because he did not know PTR could not do these things. Respondent testified that as the chief medical person at the facility he was responsible for PTR's conduct. Respondent again noted that he had been complaining to his superiors all along that a radiological technician was needed at the facility.

12. Respondent testified that during the inspection he noticed it was taking PTR a long time to produce the logs so he asked PTR what was going on. PTR indicated that he knew he should not have signed the log and taken credit for x-rays performed by Respondent. Respondent then offered to initial the x-rays he took to clarify the log. Respondent testified that he did not know this was improper. According to Respondent, the ARRA inspector was present when Respondent walked over to the log and began to initial the log until the inspector told him he could not.

13. Respondent testified that a day or so after the inspection, when PTR knew he was going to lose his job for taking credit for x-rays Respondent had taken, PTR approached Respondent and asked Respondent to indicate which films he had taken. PTR then wrote a list of the films Respondent had taken and Respondent agreed to sign the list because he knew he had taken more films than anyone else in the facility. Respondent was asked why, if he took the films and a log was required to be kept, he did not sign the log at the time he took the x-rays. Respondent testified that the facility was fast-moving and up to 100 people per day were seen so he relied on PTR to develop the film and make out the log.

14. Respondent was asked about having PTR take a patient into the x-ray room and position the patient. Respondent testified that he was responsible for allowing PTR to work outside the scope of his license. Respondent admitted that a radiologist should know the role of a PTR and radiology technician and their respective scope of practice. Respondent testified that he was not Board Certified in radiology and had not done a formal residency in radiology. Respondent noted he had been doing x-rays for approximately 40 years.

15. Respondent described the facility as providing urgent care as well as a general practice that treated people of all ages, including children. Respondent was asked whether PTR sometimes pushed the button for the x-ray or whether Respondent himself did that. Respondent testified that in some instances PTR actually pushed the button for the x-ray. Respondent noted that the ARRA report identified fifteen instances where PTR had done so. Respondent was asked the downside of allowing an inexperienced person, such as PTR, to take x-rays. Respondent noted that PTR could overexpose a patient, but he did not believe that happened. However, Respondent did admit to PTR having taken x-rays when Respondent was not present.

16. Respondent was asked to describe the staff hierarchy at the facility. Respondent noted that there was a physician to whom he reported and then there was a regional administrator. Respondent testified there was no other physician on site, but there were physician assistants that would work in the evenings. Respondent was asked to describe his express responsibilities at the facility. Respondent testified that less than one percent of his time was spent taking x-rays and the remainder he spent seeing patients. Respondent testified that his current practice is a solo practice and he does not have an x-ray machine.

17. Respondent testified that if putting his initials in the log after the fact to indicate that he took the x-ray is altering the log, then he had done so. Respondent testified that he had done so not to change the log, but to take credit for x-rays he had taken. Respondent also testified that had he known PTR could not take x-rays or position patients he would have never allowed him to do so.

18. The Board noted as aggravating factors Respondent's two prior advisory letters and prior unprofessional conduct that resulted in a Letter of Reprimand in 1993.

19. The Board noted as a mitigating factor that Respondent was placed in a position where he was asked to do something under one set of circumstances and then was placed in a situation where those circumstances changed when the radiological technician was removed from the facility.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(27)(a) ("[v]iolating any federal or state laws, rules or regulations applicable to the practice of medicine;") specifically, A.R.S. § 13-1003 and A.A.C. R12-1-603(B)(1); and A.R.S. § 32-1401(27)(ii) ("[l]ack of or inappropriate direction, collaboration or direct supervision of a medical assistant or a licensed, certified or registered health care provider employed by, supervised by or assigned to the physician.")

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED that

1. Respondent is issued a Letter of Reprimand for improper supervision of a practical technologist in radiology.

2. Respondent is placed on probation for one year with the following terms and conditions:

a. Respondent shall within 90 days of the effective date of this Order obtain 10 hours of Board Staff pre-approved Category I Continuing Medical Education ("CME") in ethics and provide Board Staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for biennial renewal of medical license. The probation will terminate when Respondent supplies proof of course completion satisfactory to Board Staff.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-102. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 10th day of March, 2005.

THE ARIZONA MEDICAL BOARD

By _____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 10th day of March, 2005 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Certified Mail this 10th day of March, 2005, to:

L. Wayne Finley, M.D.
Address of Record